MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Qualified Health Plans 01-01

Issued: January 1, 2001

Subject: HEDIS Data Reporting

Effective: February 1, 2001

Programs Affected: Medicaid

The Medical Services Administration is issuing revised instructions pertaining to Health Plan Employer Data Information Set (HEDIS®) data reporting. The revised instructions are included in the attached Chapter VIII of the HMO Manual. **Please note: health plans are required to continue submission of quarterly utilization reports as outlined in MSA 98-05 Bulletin until the health plan receives written notification from DCH that their quarterly report requirement is waived in lieu of acceptable encounter data submissions.**

Manual Update

Replace your entire Qualified Health Plan Manual, Chapter VIII with the attached pages.

Questions

All questions regarding commercial licensure and/or reporting requirements should be directed to your health plan's Regulatory Analyst at the Office of Financial and Insurance Services.

All questions related to the technical specifications and interpretations of the reporting requirements of HEDIS® and/or the data submission tool (DST) should be directed to the National Committee on Quality Assurance (NCQA) or your health plan's contracted NCQA certified HEDIS® compliance auditor.

- For questions on data specifications and/or interpretation of the reporting requirements health plans may call the HEDIS® Support line at 202-955-1796 or submit an inquiry to the Technical Inquiry Section at TIL@ncqa.org.

- For technical questions on the DST contact NCQA, your health plan's contracted NCQA certified HEDIS® compliance auditor or the NCQA number included with your health plan's DST.

Approved

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GENERAL INFORMATION

Health plans contracted with the State of Michigan through the Department of Community Health (DCH) for the purposes of enrolling and providing care to Michigan Medicaid beneficiaries are required to report annual performance data to DCH using the National Committee for Quality Assurance's (NCQA) Health Plan Employer Data and Information Set (HEDIS®) reporting version that is applicable to the reporting period. Annually, health plans must:

- Secure an audit opinion from a NCQA certified HEDIS® compliance auditing firm and lead auditor.
- Submit two hard copies of the audited Medicaid HEDIS® Data Submission Tool (DST) and two electronic copies of the audited Medicaid HEDIS® DSTs on two 3.5 1.44 capacity formatted discs to the plan's contract manager on or before June 30 of each year.
- Submit a copy of the signed and dated Final Audit Statement along with the DST.
- Submit a copy of the signed and dated "Attestation of Accuracy and Public reporting Authorization-Medicaid" along with the DST.
- Submit two hard copies of the health plan's HEDIS® compliance audit report by September 30 of the reporting year.

Health plans that have Medicaid enrollees for any period in a reporting year must submit an annual HEDIS® report following the current technical specifications for all applicable measures. Health plans that are operational or contracted for a partial year must complete all measures required by NCQA, excluding those that cannot be computed due to continuous enrollment requirements.

As stated in the Request for Proposal and the Contract between the Department of Management and Budget and the health plan (and/or DCH and the health plan) sanctions and/or remedies may be imposed on the health plan for failure to meet the reporting requirements described herein. The application of sanctions and remedies will be a matter of public record.

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ANNUAL HEDIS® REPORTING CONTENT GUIDELINES

For all contract annual reporting periods, the annual reports must be in compliance with the latest technical specifications as published by NCQA in Volume 2, HEDIS® Technical Specifications manual .

Health plans are not responsible for reporting measures for services that are not required by the contract such as dental, or inpatient mental health services for which the health plans do not have required inpatient mental health hospitalization data. Further, health plans are not responsible for reporting measures dependent upon Medicaid membership data not provided by DCH to the health plans .

Health plans are required to perform an annual adult and child Consumer Assessment of Health Plan Study (CAHPS®) consumer survey as specified by HEDIS®. During the period that DCH contracts with and directly pays a vendor to conduct the Medicaid CAHPS ® survey, health plans do not have to report the Satisfaction with the Experiences of Care measure. However, if a plan chooses to directly contract with its own NCQA certified survey vendor , or at a later date should DCH no longer directly contract with a survey vendor , health plans will be required to directly contract with and pay a CAHPS ® vendor to conduct the adult and child CAHPS ® surveys in accordance with HEDIS ® technical specifications. Health plans will then be required to submit both member level and summary level results of its Medicaid adult and child member surveys.

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DEFINITION OF REPORTING CATEGORIES

The following definitions are provided for health plans to sort their encounter and/or utilization data according to the reporting categories as defined under the Health Plan Descriptive Information and Enrollment by Payer Measures. These same category definitions should also be applied to all other Use of Services measures where HEDIS ® requires reporting by payer category. Health plans are to use the information that DCH' s enrollment broker sends in the monthly enrollment files to sort member data as indicated below.

Category A : Total Medicaid

- All members enrolled in the health plan who receive Medicaid benefits, including those who receive a restricted benefit package .
- Medicaid Restricted Benefits

  Program Code = L

  Age ≥ 16

  Sex = Female

Category B: Medicaid/Medicare Dual Eligibles

- Other Insurance Code ≥ 90 **AND** ≠ Category A
- Age = Any
- Sex = Either

Category C: Medicaid Disabled

- Program Code = P or E **AND** ≠ Category A or B
- Age = Any
- Sex = Either

Category D: Medicaid Other Low Income

- All persons not in Category A, B or C as defined above.

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PRODUCTION SCHEDULE

By June 30 health plans are to submit their annual Medicaid HEDIS ® Report to include :

- two hard copies and two electronic copies of the Medicaid HEDIS ® DSTs on 3.5 1.44 capacity formatted discs
- a copy of and the NCQA certified HEDIS ® compliance auditor' s signed and dated Final Audit Statement
- a copy of the health plan' s signed and dated " Attestation of Accuracy and Public reporting Authorization-Medicaid" letter

In addition, by September 30 health plans are to submit:

- two hard copies of the health plan ' s HEDIS ® compliance audit

The annual Medicaid HEDIS ® Report should be submitted to the health plan' s contract manager at the following address:

Comprehensive Health Plan Division
Department of Community Health
400 S. Pine
PO Box 30479
Lansing, MI 48909-7979

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